ATTACHMENT B
Procedure for Continuity of
Prior Authorized Services for Adults
TRANSITION FROM A MANAGED CARE ORGANIZATION TO FEE-FOR-SERVICE

*****REMINDER: Providers must check the Eligibility Verification System (EVS) prior to providing any service to an eligible Medical Assistance (M A) recipient and must listen to the entire EVS message in order to obtain the correct eligibility information necessary for payment.**

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1. If a provider learns, through EVS or otherwise, that a recipient who was enrolled in a managed care organization (MCO) and successfully received a prior authorization for services from the MCO with "from" and "to" dates, disenrolls from the MCO and returns to the M A fee-for-service (FFS) delivery system, the MCO provider must call the Department of Public Welfare's (DPW's) Prior Authorization Unit at (717) 772-6181 and inform them of the existing prior authorization for services.

2. When the Department receives the phone call, the provider will be instructed to submit a copy of the MCO's prior authorization (or PCP's referral form). Upon receipt of the MCOs prior authorization (or PCP referral form), the Department must either:

   A) approve the service and honor the amount, duration/frequency and scope of services specified by the MCO's prior authorization. The Department, in approving the services, will reimburse at the established M A fee and advise the provider of procedures for billing. The provider delivers the service to the recipient and does not invoice the MCO but invoices the Department according to FFS billing procedures;

   OR

   B) approve the amount, duration/ frequency and scope of services pending a concurrent clinical review of the continued need for the MCO's prior authorized services. **Under no circumstances may the Department withhold authorization to continue the services, reduce, delay or interrupt the receipt of the services pending the concurrent review.**

3. If, as a result of the concurrent review, the Department issues a denial by authorizing an alternative course of treatment, or reducing or terminating the MCO's approved prior authorization, the Department must provide proper written notification of the changes to the recipient and the prescribing provider and honor the recipient's right to exercise his/her fair hearing rights.

   If the recipient/enrollee has been receiving the services that are being reduced, changed, or denied and they file a request for a fair hearing that is hand

delivered or postmarked within 10 days of the date of the written notice of decision, the services will continue until the fair hearing decision is made.

4. If the provider proposes to continue the prior authorized service, the appropriate FFS request must be submitted to the Department in sufficient time prior to the end of the approval period to allow the Department adequate time to reassess the need for service and make a determination of medical necessity ten days before the end of the previously approved period. If the Department decides to deny the request either in full or by authorizing a change in the amount or duration of services, or alternative services, the Department must notify the recipient and prescribing provider in writing at least ten days in advance of the effective date of the proposed change in authorization. In such cases, the recipient is entitled to exercise his/her fair hearing options.